A Project to Empower the Staff Awareness in Best Practice Approach to Pain Assessment in Dementia.

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ABSTRACT

Assessing and treating physical pain and affective discomfort in people who can no longer report on their internal states is quite challenging. Since little is known about best practice in pain assessment for people with dementia, health care providers often learn while "in the trenches". This thesis reports authors' professional journey in trying to empower the staff knowledge in best practice approach to pain assessment in people with dementia. In addition, author updated the pain scale, based on literature, as a clinical tool, for supporting staff in recognition and assessment of pain in clinical practice. The change was implemented using HSE change model. Change typically results as a reaction to specific problems or opportunities the organization is facing based on internal or external stimuli. After an unannounced HIQA visit in authors' organisation, many recommendations were made; poor pain assessment was one of the identified priorities. Being a staff nurse and front line manager of the care process in authors' organisation, is responsible to ensure the pain assessment is in line with best practice and ensure the comfort of each resident. More over nurses have an ethical obligation to appropriately treat patients' pain. Kirkpatrick four level model of evaluation tool was used to evaluate the changes and revealed successful attainment of SMART objectives. Here the author intended to change the structure and process in the organisation. On reflection, author described the challenges encounter during this project, what were the strength and weakness of the project, organisational impact and future recommendations to the organisation.
I would like to express my greatest gratitude to the people who have helped & supported me throughout my project. I am grateful to programme director Steve Pitman and specially my facilitator; Margaret Boland for her continuous support for the project, from initial advice and contacts in the early stages of conceptual inception and through ongoing advice and encouragement to this day. A special thank of mine goes to my colleagues who helped me in completing the project and they exchanged their interesting ideas, thoughts and made this project easy and accurate. I wish to thank my family for their undivided support and interest who inspired me and encouraged me to go my own way, without whom I would be unable to complete my project. At last but not the least I want to thank my friends who appreciated me for my work and motivated me and finally to God who made all these things possible.
CHAPTER 1
INTRODUCTION

1.1. INTRODUCTION

Dementia is an umbrella term used to denote progressive conditions that develop as a result of degenerative changes in the brain. Dementia primarily affects older people and is characterised by the loss of cognitive, social and behavioural functions that impacts a person’s mood and personality and the ability to think, speak, comprehend, reason, communicate, remember and perform basic self-care functions like dressing and eating. As dementia progresses, the associated behavioural and functional disabilities necessitate the provision of increased daily assistance and care to the individual. Hence, the role of family caregivers in providing care can be significant (The Law Reform Commission, 2006; Cahill et al. 2012; Alzheimer’s Association, 2012).

Pain is a complex phenomenon and is frequently reported amongst nursing home residents (Hadjistavropoulos et al. 2007, Achterberg et al. 2010). However, pain in people with dementia remains under-detected and misinterpreted (Cohen-Mansfield 2005), thus challenging the care professionals’ nursing care (Nygaard & Jarland 2005, Cunningham et al. 2010). Untreated chronic pain is a devastating symptom in older people with moderate to severe dementia who are unable to explain their suffering (Scherder et al 2009).

Persistent pain has been associated with a progressive decline of functional and mental capacity (Moriatry, McGuire and Finn, 2011); social interaction (Lin, Shyu and Hua 2011); quality of life (Cipher and Cliford 2004; Cordner, Blass, Rabins and Black 2010; Jakobsson and Hallberg, 2002);
appetite (Bosley, Weiner, Rudy and Granieri, 2004); sleep disturbances (Giron et al, 2002); increased behavioural disturbance including agitation, depression and anxiety (Husebo, Ballard, and Aarsland, 2011). Moreover pain cause immense stress for the patient and their formal and informal care givers (Buffum and Haberfelde 2007); and increases health costs (Ferrell and Griffith, 1994).

All persons with pain deserve prompt recognition and treatment. Pain should be routinely monitored, assessed, reassessed, and documented clearly to facilitate treatment and communication among health care clinicians (Gordon et al., 2005). Non-use of adequate and appropriate assessment tools for measuring pain has been identified as an impediment to accurate pain assessment in people with dementia (Allcock et al., 2002). In a study investigating nursing staff knowledge and beliefs about pain in older residents with dementia, Zwakhalen et al. (2007) found knowledge deficits with regard to pain assessment. The residential care setting is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. (HIQA standard 27). There are appropriately skilled and qualified staffs sufficient to ensure that services are delivered in accordance with these standards and the needs of the residents. (HIQA standard 23). Staffs receive induction and continued professional development and appropriate supervision (HIQA Standard 24). In this chapter the author will explain the aims and objectives of the change project and rationale for carrying out the change.

**1.2. AIM**

To empower the staff awareness about a best practice approach to pain assessment in dementia and update the pain scale based on literature support and thereby improves the quality of care in my organisation.
1.3. OBJECTIVES.

1. To conduct a pre-test among the staff to get a feedback of staff awareness about best practice approach to pain assessment in dementia during the time of awareness programme.

2. To update the pain scale in my organisation based on literature and also conduct a staff awareness programme about the best practice approach to pain assessment in dementia during my implementation phase.

3. To conduct a systematic review of my study to evaluate the improvement in staff knowledge level about how to use the pain scale and best practice approach to pain assessment during the evaluation stage of my study.

1.4. RATIONAL FOR CARRYING OUT THE CHANGES

The Health Act 2007 introduced a significant change to how residential care settings for older people are inspected and registered. The new Health Act requires that all designated centres, including residential care settings for older people, must be inspected and registered, whether run by the HSE, private providers or voluntary organisations. This ensures equity of treatment across the whole sector and supports the aim of delivering consistent standards of service to residents regardless of the provider of the service. This prompted a recent unannounced inspection in my health care setting by HIQA; many recommendations were made to comply with Health Act 2007 and National Quality Standard for Older People in Ireland. This includes changes in practice, structure and process in my organisation.

Donebadian (2003), states that quality is a function of three domains, Structure, process and outcome. Structure related to the conditions under which care is provided, including material
resources, human recourses and organisational characteristics. Process related to the activities that constitute health, including diagnosis, treatment, rehabilitation, prevention, and education. Finally outcome relate to the change in individuals and populations that can be attributed to health care, including change in health status, change in knowledge, change in behaviour, and satisfaction with the care received and outcome. According to Burnes (2004), change is an ever present feature of organisational life, both at an operational and strategic level. Therefore, there should be no doubt regarding the importance to any organization of its ability to identify where it needs to be in the future, and how to manage the change required getting there. Consequently, organisational change cannot separate from organisational strategy or vice versa (Burnes, 2004, Rieley and Clarkson, 2001).

There are more than 35 million people with dementia worldwide, and this figure is set to rise to over 115 million by the year 2050 (World Health Organization (WHO), 2012). Evidence indicates that about 50% of people with dementia regularly experience pain, with more severe pain arising more commonly in people with advanced dementia (Shega, 2004). As a result, the prevalence of pain in people with dementia in care homes is particularly high, with treatment being challenging owing to the symptoms of dementia which can affect the resident's ability to communicate.

Poor pain management is an issue that has been reported frequently (Herr 2010). So assessment and management of pain are taken seriously by the inspector. Poor assessment of pain was one of the identified priority areas in my organisation. Moreover an accurate assessment of pain in people with dementia is essential for ensuring timely and appropriate treatment, as well as allowing care staff to monitor residents to ensure analgesic treatment is effective.

The rationales for carrying out this project we're following.
1. Being a staff nurse and front line manager of the care process in my organisation, is responsible to ensure the pain assessment is inline with best practice and ensure the comfort of each resident. Each resident has his/her needs assessed prior to moving into the residential care setting, a full assessment upon admission, and subsequently as required to reflect changes in need and circumstances during his/her period in residence. (HIQA standard 10).

2. Nurses have an ethical obligation to appropriately treat patients’ pain. To fulfill their ethical obligation to relieve pain in older patients, nurses often need to advocate on their behalf. The ethical principles of beneficence (the duty to benefit another) and non-maleficence (the duty to do no harm) oblige health care professionals to provide pain management and comfort to all patients, including those challenging individuals who are vulnerable and unable to speak for themselves. Providing quality and comparable care to individuals who cannot report their pain is directed by the principle of justice (the equal or comparative treatment of individuals). Respect for human dignity, the first principle in the “Code of Ethics for Nurses” (ANA, 2001), directs nurses to provide and advocate for humane and appropriate care.

3. The treatment of geriatric patients is complicated when dementia is present, because of the patient’s impaired communication abilities. Highly skilled nurse plays a vital role in pain detection. Due to rapid staff turnover and frequent complaints from the family side, I believe staff awareness is very much important in this area. There are appropriately skilled and qualified staffs sufficient to ensure that services are delivered in accordance with these standards and the needs of the residents. (HIQA standard 23).

4. A successful management of change is crucial to any organisation in order to survive and succeed in today’s highly competitive and continuously evolving business environment. (Lueche 2003).
5. This topic is selected according to the guideline for project dissertation published by The Royal College of Surgeons in Ireland.

1.5. SUMMARY.

Pain in people with dementia is a critical issue, requiring accurate identification and impeccable treatment. Despite considerable research and guidance on how to improve pain assessment for people with dementia in care homes, the evidence is that it is often poorly recognised and treated. A pain assessment strategy requires a team approach and requires every member of the team to take seriously their responsibility to deliver a successful pain assessment for people with dementia. This include being aware of and communicating to staff members, different pain words, on-verbal expression, visual expressions and change to normal behaviour. It also includes assuming and treating pain if there is no other obvious cause of change in behaviour. Regular monitoring and adjustment of pain relief are essential to ensure sufficient relief from pain.

This project was carried out to empower the staff awareness in best practice in pain assessment in dementia and update the pain scale in my organisation incompliance with both professional and national standard. Next chapter will describe a literature review of pain and dementia and the following chapter will focus on change management, evaluation of the change and the last chapter will focus on discussion and conclusion of the project.
CHAPTER 2
LITERATURE REVIEW

2.1. INTRODUCTION
A major challenge facing societies across the world today is population ageing. However, population ageing will inevitably result in an increase in disability and a very significant increase in the incidence of age-related health problems especially Alzheimer’s disease and the related dementias. Like other countries, Ireland is soon to witness a very significant growth in its ageing population and, as a result of this, a parallel increase in numbers of people likely to have dementia. In this chapter author likes do an in-depth search about pain assessment and dementia.

2.2. LITERATURE SEARCH
In order to carry out a broader search of relevant literature on this change topic, the Royal College of Surgeons in Ireland (RCSI) library, mainly CINAHL and Emerald used. Other resources include mainly from Google scholar. The search term used include, pain management in dementia, assessment of pain in dementia, pain assessment tools, best practice in pain assessments. The criteria for selection include original research article or a systematic review article.

2.3. DEFINITION OF DEMENTIA
WHO defines ‘dementia is a syndrome due to disease of the brain, usually of a chronic progressive nature, of which there is impairment of multiple higher cortical functions’...What this
definition means functions like memory, orientation, comprehension, emotions and judgement may be affected in a person with dementia. “A syndrome due to disease of the brain, usually a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Consciousness is not impaired. Impairments of cognitive functions are commonly accompanied, occasionally preceded, by deterioration in emotional control, social behaviour or motivation. This syndrome occurs in Alzheimer’s disease, with cerebrovascular disease, and in other conditions, primarily or secondarily affecting brain”. (ICD-10).

Dementia represents a significant challenge for clinicians and treatment often more complicated since the majority of people experience difficulties in communicating, particularly in the later stage of the condition, when language, cognition and self care abilities are severely impaired (Scherder et al 2009). Herr et al (2006) defined dementia as a “progressive and debilitating disease characterised by severe cognitive deficits, loss of language, and ability to carry out activities of daily living. Dementia affects the whole person: not just the brain and memory, but also a host of important aspect of daily living (Hughes, 2011: 14)

2.4. INCIDENTS AND PREVALENCES

2.4.1. In Ireland

The population of older people (those aged 65 and over) who currently represent 11% of our total population is expected to double from approximately 0.5million today to over 1 million by 2031. A review undertaken for Ireland’s National Dementia Strategy provides evidence on the prevalence of dementia indicate that there are 41,740 people with dementia in Ireland, most of whom are over 65 years of age (Cahill et al. 2012).The 2006 prevalence data for Ireland suggest that 3583 of estimated 41740 had early onset of dementia and most of these were young men
2.4.2. Global estimates

The number of people around the world likely to have dementia in 2010 was 35.6 million (Prince 2009). In Europe the number of people currently estimated to have dementia is over 7.7 million (Alzheimer Europe 2009). Based on United Nations (UN) population projections, they estimated that world wide dementia prevalence rates would double every 20 years to 42 million by 2020 and 81 million by 2040. Ferri et al (2005) estimated that 4.9 million people were living with dementia in Western Europe and forecast that this figure would rise to 9.9 million by 2040. Prince (2009) estimates by 2010 there were approximately 7 million Western Europeans with dementia and forecast that these numbers would increase to 10 million in 2030 and to 13.4 million in 2050.

2.5. NEW GOVERNMENT PLANS

The Irish government has given a commitment in the Programme of Government for 2011-2016 to develop and implement a Strategy for Dementia for Ireland, promising to: “develop a national Alzheimer’s and other dementia strategy by 2013 to increase awareness, ensure early diagnosis and prevention, and development of enhanced community based services. This strategy will be implemented over 5 years”. The new strategy has the potential to bring about a major change in public attitudes to dementia in Ireland and to change expectations in regard to the right of people with dementia.

2.6. ECONOMIC AND SOCIAL COST OF DEMENTIA

“The allocation of recourses to dementia is ultimately a political decision that can be influenced by stakeholders and public opinion (Cahill, O'Shea and Pierce 2012)”. The recent world Alzheimer Report estimated the world wide cost of dementia to be in the region of US $604
billion (Wimo and Prince 2010). Wimo et al (2011) UK study found the total cost of dementia to be in the region of £23 billion (Luengo-Fernandez et al 2010). Our recent research review has estimated that the overall economic cost of dementia in Ireland in 2010 was €1.69 billion.

2.7. DEFINITION OF PAIN

Pain is the most common symptom of any illness. “It is an unpleasant sensory and emotional experience associated with either actual or potential tissue damage or describe in terms of such damage” (IAPS). Or pain is whatever the experiencing person says it is, existing whenever he/she says it does (McCaffery). It is a highly individual experience shaped by context and beliefs about its meaning (Farrel MJ, Katz B, Helme RD).

2.8. PAIN AND DEMENTIA

The literature suggests that pain is a common phenomenon in older people with dementia (e.g. MacDonald & Hilton, 2001; Pickering et al., 2006; McAuliffe et al., 2009). Pain is not a normal part of the ageing process; rather, it is related to concurrent disease states such as cancer and arthritis (Forrest 1995). It is important to note that residents with dementia are no different from their cognitively intact peers in their potential to experience pain from physiological or emotional causes (Parmalee, Smith, and Katz 1993). Older people form the population most at risk of having their pain inadequately assessed, and this is especially so for those with dementia (Weiner & Hanlon 2001).

2.9. REASONS FOR UNDETECTED/ UNDERTREATED PAIN

The reasons for the under assessment and under treatment of pain in older adults with dementia are numerous (McAuliffe et al., 2009) Pain in people with dementia remains under treated and misinterpreted (Cohen-Mansfield-2005). There is a high risk of under detection of pain in
dementia, particularly in those with limited verbal communications. Along with under-detection, pain is often under treated in people with dementia (Collett 2002). This occurs for the variety of reasons, including the inability of person with dementia to recognise and articulate pain, lack of recognition by cares of the behavioural and non verbal signs that someone is in pain, lack of awareness of chronic pain (Cohen- Mansfield and Lipson 2008). Moreover reliance of non-professional staff for the personal care (Horgas and Dunn 2001).

According to the American Pain Foundation (2008), the reasons that may contribute to the under treatment of pain in older people include misconceptions regarding the aging process, difficulty accessing care, and the stigma associated with admission of pain. Elderly patients traditionally underreport pain, believing it is a part of normal aging. Also, older people may have a fear of addiction, tolerance, hyper analgesia, and side effects such as constipation or sedation. Many older adults have coexisting conditions that can make pain difficult to manage. The idea that opioids adversely impact the quality of life is also a common misconception. Good pain assessment is essential for good pain management. Studies comparing clinician assessment with patients’ actual pain ratings frequently confirm that clinicians underestimate levels of pain (Gunnarsdottir et al 2003, Zolan 1993). Curtiss (2001) identifies the most powerful predictor of pain management as the discrepancy between patients’ and clinicians’ perception of pain.

2.10. CAUSES OF PAIN IN PEOPLE WITH DEMENTIA

Although dementia does not cause pain in itself (as far as has been ascertained by research), older people with dementia are susceptible to the same pain-causing conditions that affect older people without dementia. The most common cause of pain in older people is chronic musculoskeletal pain, which affect over 100 million people in Europe, leading to problems with
mobility, including falls, and mental and physical well-being (Corbet et al. 2012). Pain in older people is associated with chronic underlying health disorders (e.g. Arthritis, peripheral vascular disease) and acute pain conditions such as cancer and surgical procedures. The medical comorbidity has, however, been found to increase significantly with dementia severity (Doraiswamy et al., 2002; Black et al., 2006).

People with dementia in care homes also experience pain as a result of other common conditions including genitor urinary infections pressure ulcers, gastro intestinal complications, cardiac issues and other skin problems, often experiencing multiple conditions that contribute to their pain (Black et al. 2006). Hampered further by the inability to communicate effectively, people with severe dementia may also be unable to report disease symptoms which in turn complicate the diagnosis of other pain-causing co-morbid conditions (Black et al., 2006). Falls are most likely to occur in older patients, and they are much more likely to experience serious injury (NPSA 2007). Most falls are not caused by a single risk factor, but occur due to the interaction of several determinants (WHO, 2007).

For patients with dementia, the consequences of pressure ulcers represent a major burden of sickness and reduced quality of life (Clark et al, 2004). Constipation and urinary tract infections occur frequently and can cause great distress. Sitting and lying in one position and uncomfortable or tight clothes or shoes can lead to pressure sores. The weight loss associated with dementia may lead to ill-fitting dentures and sore gums. Those who have teeth may lose the ability to clean them properly, causing tooth decay or abscesses. Some studies have found that people with dementia, particularly those residing in care homes may have undiagnosed
fracture leading to great pain and distress.

2.11. SIGNS AND SYMPTOMS OF PAIN IN DEMENTIA

Pain is a major cause of behavioural and psychological symptoms of dementia, such as aggression, agitation and psychosis (hallucinations and delusions), and mood disorders such as depression (Hall-Lord, 2003). Common pain behaviour in person with dementia includes facial expression (e.g.: frowning, grimacing, distorted expression, rapid blinking), verbalisation/vocalisation (e.g. Sighing, moaning, calling out, asking for help, verbal abuse), body movement (e.g. Rigid, tense, guarding, fidgeting, increased pacing/rocking, mobility changes such as inactivity or motor restlessness), change in interpersonal interactions (e.g. Aggressive, resisting care, disruptive, withdrawn), change in activity patterns (appetite change, sleep change, sudden cessation of common routine) and mental status change (e.g. crying, increased confusion, irritability distress). Patient may display increased irritability or aggressive behaviour, increased resistance to personal care requiring active or passive movement, change in appetite or sleep, slowed healing, impaired physical mobility, depressive symptoms or social withdrawal (Cook et al 1999, Feldt 2000, Ferrell et al 1995, Miller et al 2000).

2.12. BARRIORS OF SUCCESSFUL PAIN ASSESSMENT

A number of perceived barriers to successful pain assessment in people with dementia were identified in the literature. Discussion of these barriers appears under two main headings. They are staff considerations and people with dementia considerations.

2.12.1 Staff considerations

1. Lack of recognition. Pain is often not assessed because it fails to be recognized and subsequently diagnosed (Madjar & Higgins 1996). Madjar and Higgins found that there was a
high prevalence of chronic pain in nursing home residents, some of which went unrecognized by staff, and that chronic pain was rarely listed either as a medical or nursing diagnosis or detailed in nursing plans.

2. Insufficient education and/or training. Insufficient education and/or training, both perceived and actual, have been identified as barriers to effective pain assessment in people with dementia. Cohen Mansfield and Creedon (2002, p. 70) found that many nurses were ‘constrained by their training and by personal habitual ways of conceptualizing the situation’, such as believing that a behavioural problem was the result of psychological distress and therefore required specific interventions, rather than looking for potentially different causes of the behaviour.

3. Misdiagnosis or late diagnosis. Symptoms associated with pain in dementia are often misinterpreted, resulting in misdiagnosis and/or late diagnosis. Kovach et al. (2000) found that analgesics were often only administered after treatment with psychotropic drugs had been unsuccessful. Kaasalainen et al. (2007) reported that residents’ behaviours were mostly considered to be indicative of something other than pain, with pain often investigated and assessed as a last resort in residents with dementia.

4. Non-use of assessment tools. Non-use of adequate and appropriate assessment tools for measuring pain has been identified as an impediment to accurate pain assessment in people with dementia. Allcock et al. (2002) found that 75% of the nursing homes in their study did not use a standardized pain assessment tool, with at least 84% relying on self-report and/or observation by nursing or care staff. Madjar and Higgins (1996) found that no systematic or comprehensive instruments were used to assess or document pain.
2.12.2 People with dementia considerations

1. Insufficient evidence: Cohen Mansfield and Creedon (2002) identified a lack of sufficient evidence as a barrier to the detection of pain in older adults with dementia. They found that behaviours needed to be repeated several times and observed in the presence of the same caregiver before they were linked to pain.

2. Possible ‘no pain’ subset of people with dementia: Fisher-Morris and Gellatly (1997) have suggested there may be a subset of people with dementia who have what would normally be identified as painful conditions, but who do not experience pain.

3. Type of pain: The findings of several studies indicate that distinguishing between different types of pain can be a difficulty that prevents successful pain assessment. Cohen. Adams et al. (1997) also found that nurses relied on physiological changes such as changes in vital signs, guarding, and pallor to alert them that a person with dementia was experiencing pain, and these signs were found to be indicative of acute, but not chronic, pain. Coupled with the finding that nurses stress the use of behavioural change to indicate pain, this further suggests that chronic pain may be especially susceptible to under-detection.

4. Stoical attitudes. Certain attitudes held by older adults experiencing pain may also serve as obstacles to accurate pain assessment. In a study of older people in nursing homes (both with and without dementia) Madjar and Higgins (1996) found that most residents expressed stoical attitudes and accepted their pain as part of the ageing process. Common themes identified were a fear of drug (analgesic) addiction, reporting pain seen as complaining, and doubts that effective pain relief was actually possible.
2.13. STRATEGIES FOR OVERCOMING BARRIERS

1. Knowing the person: Several studies highlighted the importance of knowing the person in making an accurate assessment of pain in people with dementia. The nurses in Parke’s (1998) study reported that they used pain cues such as changes in overt behaviours to indicate that a person might be in pain, and that this method of assessment could only be undertaken if there was familiarity with the person. Cohen Mansfield and Creedon (2002) further support the notion that knowing the person can assist in detecting and assessing their pain.

2. Knowing by diversity/intuitive perception: Parke (1998) identified a second way of knowing, namely knowing by diversity or knowing by intuitive perception. Parke explained this knowledge as intuitive in nature, derived from each nurse’s diverse range of clinical experiences of people with dementia in pain.

3. Education and training: Many of the barriers to pain assessment in older adults with dementia can be overcome by the introduction of more extensive and informative education and training about both the manifestations of pain in these patients and the process of assessment needed for the pain to be detected.

4. Adequate tools: It is evident from the literature that increasing the success of pain assessments in older adults with dementia is largely dependent on the development and implementation of an adequate pain assessment tool for this population.

2.14. ASSESSMENT OF PAIN IN DEMENTIA

Pain in people with dementia can be manifested in a variety of ways, and these are often difficult for professional care-givers to interpret (Blomqvist 2002). Misdiagnosing and over- or
underestimating pain may lead to inappropriate medication and unnecessary suffering (Cunningham et al. 2010). Furthermore, with the global increase in dementia (Ferri et al. 2005), it is vital to address pain detection issues to improve care provision for those who are suffering from pain.

Assessment of pain involves the gathering of information through asking questions about symptoms. Various words describing pain may have to be used to explore the language that the older person is used to, words such as 'ache', 'discomfort' or 'soreness'. In mild and moderate dementia, where language is not grossly impaired, the person is likely to be able to answer questions about pain. However, it is important to clarify that just because a person can use language, it does not mean that they understand what is being said, can convert what they are feeling into the correct words or even communicate this. The clinician should attempt to verify verbal reports by patient observation and by repeated assessment.

2.14.1 Self report of pain.

Most research on self-reporting of pain in older people with cognitive impairment has been undertaken in the past five years (Pautex et al 2006, Horgas et al 2009, Pesonen et al 2009). Self-report is considered the gold standard of pain measurement because it is consistent with the definition of pain. Pain is a subjective experience. Self-report of pain is a highly valid and widely used approach in most patient groups, it is less reliable in dementia where individuals may have less insight into their condition, and a reduced capacity to communicate discomfort (Merksey, 1994).

One of the most important cues that judges rely on when assessing pain is the patient’s verbal report and this cue is often missing in cognitively impaired patients (Kappesser, Williams & Prkachin, 2006). However, self-report might still be an appropriate method for pain assessment.
in the early stages of dementia, when the patients are still able to recognize and verbalize pain (Corbett et al., 2012). Most research suggests that self-reporting tools are effective and appropriate for the assessment of older adults with mild to moderate cognitive impairment (Ferrel et al. 1995, Pautex et al. 2005, 2006, Horgas et al. 2009, Pesonen et al. 2009). Uncommunicative individuals or those with severe cognitive impairment, self-reporting of pain may not be possible. For this reason, several pain behaviour observational tools have been designed.

**2.14.2. Searches for Potential Causes of Pain/Discomfort.**

Consider chronic pain causes common in older persons (e.g., history of arthritis, low back pain, neuropathies). Musculoskeletal and neurological disorders are the most common causes of pain and should be given priority in the assessment process. A recent fall or other acute pain-related problem (e.g., urinary tract infection, pneumonia, skin tear) could be the cause of pain. The most common cause of pain in older people is chronic musculoskeletal pain (Corbett et al., 2012). People with dementia in care homes also experience pain as a result of other common conditions, including genitourinary infections, pressure ulcers, gastrointestinal complications, cardiac issues and other skin problems, often experiencing multiple conditions that contribute to their pain (Black et al., 2006).

**2.14.3. Surrogate Reporting of Pain (e.g., family, caregiver).**

In the long-term care setting, the certified nursing assistant is a key health care provider who has been shown to be effective in recognizing the presence of pain (Fisher et al., 2002; Mentes et al., 2004). Education on screening for pain should be a component of all certified nursing assistant training. Family members are likely to be the caregiver with the most familiarity with typical pain behaviours or changes in usual activities that might suggest pain presence in the acute care setting and in other settings in which the health care providers do not have a history.
with the patient (Co- hen-Mansfield, 2002; Shega et al., 2004).

2.14.4. Pain behaviour observational tools

In the absence of self report, observation of behaviour is a valid approach to pain assessment. Pain should be routinely monitored, assessed, reassessed, and documented clearly to facilitate treatment and communication among health care clinicians (Gordon et al., 2005). In patients who are unable to self-report pain, other measures must be used to detect pain and evaluate interventions. Assessing pain using behavioural indicators can assist healthcare professionals at this stage. There are a number of non-verbal behavioural indicator pain-assessment scales available (Herr et al., 2006a; Zwakhalen et al., 2006).

2.15. COMPARISON OF DIFFERENT TYPES OF PAIN SCALES

The Checklist of Nonverbal Pain Indicators (CNPI) scale was tested in an acute setting and participants included those with and without mild to moderate dementia. The internal consistency of the CNPI scale was low during rest and movement, thus limiting its clinical usefulness (Feldt 2000). The Discomfort Scale for patients with Dementia of the Alzheimer’s Type (DS-DAT) (Hurley et al 1992) was one of the first behaviour observational scales to show good validity; however, nurses have reported difficulty in using it and some refinement may therefore be necessary (Tsai and Chang 2004). The Abbey Scale is useful in clinical practice because it takes less than one minute to complete; however, the reliability was low, which the authors claim was because staff were too busy to spend time comparing results (Abbey et al 2004).

In the Netherlands, the recently developed guideline “chronic pain in vulnerable elderly” (Herkenning en behandeling van chronische pijn bij kwetsbare ouderen, Verenso 2011) identified several instruments that are available in Dutch. Based on psychometric properties and feasibility,
three are recommended: PACSLAC-D (a short-ended version of the Pain Assessment Checklist for Seniors with limited Ability To Communicate; Fuchs-Lacelle & Hadistavropoulos, 2004), PAINAD (The Pain Assessment in Advanced Dementia; Warden, Hurley & Volicer, 2003) and Doloplus (Lefebvre-Chapiro, 2001). In Norway, a recently developed observational tool, the MOBID-2 (The Mobilization–Observation–Behaviour—Intensity–Dementia) Pain Scale (Husebo et al., 2007; Husebo, Strand, Moe-Nilssen, Husebo & Ljunggren, 2009; Husebo et al., 2010) is used in nursing home settings.

The PACSLAC was first developed and tested by Fuchs-Lacelle and Hadjistavropoulos (2004). Zwakhalen et al (2007) developed a shorter and more manageable version of the PACSLAC to improve its clinical usefulness and tested it on 128 dementia care ward residents, 47.7% of whom had severe impairment, 28.1% had moderate impairment and 21.9% had mild impairment. In brief PACSLAC scale was as effective as the full scale (Zwakhalen et al2007).

MOBID-2 (The Mobilization–Observation–Behaviour—Intensity–Dementia) Pain Scale (Husebo et al., 2007; Husebo, Strand, Moe-Nilssen, Husebo & Ljunggren, 2009; Husebo et al., 2010) the assessment of pain intensity is based on the patient’s immediate pain behaviour (vocalization, facial expression, and body movements) in connection with standardized, guided movements of different body parts, and pain behaviour related to internal organs. The total MOBID-2 score (0–10) is derived from caregivers in a clinical bedside situation during morning care. Psychometric property studies have indicated high to excellent reliability and validity, and the assessment tool has been found feasible to use in clinical practice (Husebo et al., 2007, 2009, 2010; Husebo, Ballard, Sandvik, Nilsen & Aarsland, 2011).

The Chinese version of the Pain Assessment in Advanced Dementia (C-PAINAD) was the
assessment method selected, as it has the most evidence supporting its psychometric properties and clinical use (Warden et al. 2003, Peng et al. 2007, Herr 2010). This tool consists of five pain behaviours: breathing, negative vocalisation, facial expressions, body language and consolability. Each behaviour is rated from 0 to 2 according to the severity of the behaviour exhibited, thus giving a total score of 10. This scale is easy to use (Corbett et al, 2012).

2.16. APPROPRIATE PAIN SCALE FOR MY ORGANISATION

From the above discussion, I do believe MOBID-2 and PAINAD is suitable for my organization. Corbett et al (2012) recommends that clinicians use a combination of two assessment tools, with treatment administered if either tool indicates that the individual is in pain (Corbett et al, 2012). To enable staff to monitor the effect of treatment and ensure ongoing care is appropriate for the individual's condition, they should utilise the same two-measure approach following administration of treatment. Mobilization-Observation- Behaviour-intensity- Dementia (MOBID-2) Pain Scale adds new perspectives related to the location of pain and relationship of behaviour and pain intensity. Excellent reliability, validity and feasibility in clinical settings. (Corbett et al, 2012). Pain Assessment in Advanced Dementia (PAINAD) is easy to use (Corbett et al, 2012).

2.17. ADVOCACY

The nurse should be an advocate for patients (Nursing and Midwifery Council 2008). Advocacy may involve interaction not only with the patient, but with other parties involved in health care, such as lay carers, medical colleagues and occupational therapists, etc. In advocating for a person with dementia where pain is involved certain ethical principles apply (McClean and Cunningham 2007). These principles include: Respecting the person’s dignity, enabling choice for the person or their representative, preserving continuity, which involves attempting to connect the person with their personal history, promoting equity, doing the person no harm.
2.18. WHY NURSE AWARENESS IS IMPORTANT.

There are appropriately skilled and qualified staffs sufficient to ensure that services are delivered in accordance with these standards and the needs of the residents. (HIQA standard 23). Staffs receive induction and continued professional development and appropriate supervision (HIQA Standard 24). All nursing staffs are, where possible, facilitated to undertake a relevant post-registration qualification in the nursing and care of older people (HIQA Standard 24.1). Alongside the need for an enhanced understanding of pain mechanisms, there is also a requirement for healthcare professionals to gain the necessary skills, knowledge and expertise to enhance pain assessment and management practices. This is of particular importance as it well documented that the pain assessment is the first most important step to any pain management process (Brown 2011).
TABLE 1: BEST PRACTICE APPROACH TO PAIN ASSESSMENT.

<table>
<thead>
<tr>
<th>BEST PRACTICE APPROACH TO PAIN ASSESSMENT IN DEMENTIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pain identification is an ongoing process that should occur:</td>
</tr>
<tr>
<td>• On admission</td>
</tr>
<tr>
<td>• In the event of a significant changes in resident’s condition</td>
</tr>
<tr>
<td>• Any time pain is suspected</td>
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<tr>
<td>• At least every three months</td>
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<tr>
<td>2. Pain identification requires a two-part approach, using staff observation techniques and residents' self-report of pain.</td>
</tr>
<tr>
<td>A. ASK the person if he or she is experiencing pain</td>
</tr>
<tr>
<td>a. Use yes/no questions</td>
</tr>
<tr>
<td>b. Try words besides pain like hurt/ache/sore</td>
</tr>
<tr>
<td>B. LOOK for behavioural signs of pain or discomfort:</td>
</tr>
<tr>
<td>• Observations should be made both when the patient is at rest, and during movement (observe the patient during care activities that require movement such as bathing, dressing, or transfers and/or the physician could conduct gentle range of motion movements with the suspected pain site and watch the patient's reactions)</td>
</tr>
<tr>
<td>• Facial expressions (frowning, grimacing, distorted expression, rapid blinking), verbalizations/vocalizations (sighing, moaning, calling out, asking for help, verbal abuse)</td>
</tr>
<tr>
<td>• Body movements (rigid, tense, guarding, fidgeting, increased pacing/rocking, mobility changes)</td>
</tr>
<tr>
<td>C. INVESTIGATE for recent behavioural changes that might be due to pain.</td>
</tr>
</tbody>
</table>
a. Changes in interpersonal interactions (aggressive, resisting care, disruptive, withdrawn)

b. Changes in activity patterns (appetite change, sleep change, sudden cessation of common routines)

c. Mental status changes (crying, increased confusion, irritability, distress).

3. Pain needs to be properly diagnosed so that appropriate and effective management strategies can be planned. Diagnosis will explore the specific type of pain being experienced.

- Nociceptive pain. (Visceral or somatic pain).
- Neuropathic pain
- Pain related to psychological or psychiatric factors.

4. A thorough pain assessment explores multiple factors. These include:

- Pain history
- General medical history
- Physical examination
- Physical impact of the pain
- Social impact of the pain
- Psychosocial factors related to the pain
- A review of medications and treatments
- Severity and intensity of the pain
- Prognosis.

5. The use of an appropriate, structured pain assessment tool will facilitate thorough assessment of a resident’s pain.

*Guideline Created for Geriatrics by L Snow, MP Rapp, M Kunik and Australian pain society.*
2.19. CONCLUSION

In this chapter author discussed about pain and dementia, its incidents and prevalence, cost of dementia care, reasons for undetected pain in dementia, causes of pain in dementia, signs and symptoms of pain in dementia, barriers to successful pain assessments, strategies for overcoming barriers to successful pain assessments, assessment of pain in dementia, advocacy, and best practice approach to pain assessment. Next chapter will provide a detailed description of change and its management. It will focus on how modern change management theories were applied in implementing an evidence based study.
CHAPTER 3
ORGANISATIONAL CHANGE

3.1. INTRODUCTION

Change is an ongoing and never-ending process of organizational life. Although we would like to explain, predict, and control the process, organizational change often does not unfold in expected ways (Burke, 2009). The ability of organizations to manage and survive change is becoming increasingly important in an environment where competition and globalization of markets are ever intensifying (Cao and McHugh, 2005: 475). The mid-20th century, there had been increased attempts to apply theories of organizational change to the analysis of human organizations (Byeon, 2005: 223). In this chapter author like to explain about the organisational change, theories and models of organisational change, various type of change models and also discussed how the change implemented in authors organisation.

It can be argued that the successful management of change is crucial to any organisation in order to survive and succeed in the present highly competitive and continuously evolving business environment. Burnes noted that organisational change refers to understanding alterations within organisation at the broadest level among individuals, groups, and at the collective level across the entire organisation (1996). Another definition of change is the observation of difference over time in one or more dimension of an entity (Van de Ven and Poole, 1995).
3.2. ORGANISATIONAL DEVELOPMENT

Organisational development (OD) is a field of study that addresses change and how it affects organizations and the individuals within those organizations. Effective organizational development can assist organizations and individuals to cope with change. The ability of organizations to manage and survive change is becoming increasingly important in an environment where competition and globalization of markets are ever intensifying (Cao and McHugh, 2005: 475).

3.3. CHANGE MANAGEMENT

Change management has been defined as ‘the process of continually renewing an organization’s direction, structure, and capabilities to serve the ever-changing needs of external and internal customers’ (Moran and Brightman, 2001: 111). According to Burnes (2004) change is an ever-present feature of organisational life, both at an operational and strategic level. Therefore, there should be no doubt regarding the importance to any organisation of its ability to identify where it needs to be in the future, and how to manage the changes required getting there. Consequently, organisational change cannot be separated from organisational strategy, or vice versa (Burnes, 2004; Rieley and Clarkson, 2001). Before going into various approaches to author’s organisational change, I would like to examine the different models and theories of organisational changes.

3.4. THEORIES AND MODELS OF ORGANISATIONAL CHANGE

Models are helpful for assessing change at macro level- the level at which many institutional leaders view (should view) their organisation. Model can reveal why changes occur (the driving
force); how changes will occur (the stages, scale, timing and process characteristics); and what will occur (the content of change, outcomes, and ways to measure it). Choosing model is not an arbitrary choice- it is an ideological one. Furthermore, each model helps us to understand different aspect of change. Four main categories of theories of change assist in understanding, describing and developing insight about the change process. They are evolutionary, teleological, life cycle, dialectical, social cognition and culture. Each model has a distinct set of assumptions about why changes occur, how the process unfolds, when changes occurs and how long it takes and the outcomes of change.

3.5. TYPOLOGY OF ORGANISATIONAL CHANGE

There are some traditional typologies and new category typologies in literature. Here I am discussing the most comprehensive typologies offered by Van de Ven and Poole 1995. They described this typology as following category- teleology (planned change), life cycle (regulatory change), dialectics (conflictive change), and evolution (competitive change).

A teleology or planned change model views development as a repetitive sequence of goal formulation, implementation, evaluation, and modification of an envisioned end state based on what was learned or intended by the people involved. A life cycle model depicts the process of change as progressing through a prescribed sequence of stages and activities over time. Evolutionary change unfolds as a recurrent and probabilistic progression of variation, selection, and retention activities (Campbell, 1969). In this theory change is depends on circumstances, situational variables and the environment faced by each organisation ( Morgan 1986) . Dialectical theories explain stability and change in terms of the relative balance of power between opposing entities. Power is central to dialectical model of change.
Organizations change with the dynamics of the world. To enable organizations to change, certain structures and capabilities are needed. Several change management models are available, all depict change is a multi-step process. Examples of change models include, Kurt Lewin model (1950), Kotter’s 8 step model (Kotter1995), Young’s model (young 2009), Health Service Executive (HSE) change model (HSE model 2008). Some of these are discussed below.

3.6.1. Lewin’s change model.

One of the corner stone of understanding organisational change was developed by Kurt Lewin in
the 1950s. His model known as Unfreeze – change -Refreeze, refers to the three stage process of change he describes. Lewin is now mainly remembered as the originator of the 3-Step model of change (Cummings and Huse, 1989; Schein, 1988).

Step 1: Unfreezing. Lewin believed that the stability of human behaviour was based on a quasi-stationary equilibrium supported by a complex field of driving and restraining forces. He argued that the equilibrium needs to be stabilized (unfrozen) before old behaviour can be discarded (unlearnt) and new behaviour successfully adopted.

Step 2: Moving. Lewin’s view is that any attempt to predict or identify a specific outcome from planned change is very difficult because of the complexity of the forces concerned. Instead, one should seek to take into account all the forces at work and identify and evaluate, on a trial and error basis, all the available options (Lewin, 1947a).

Step 3. Refreezing. This is the final step in the 3-Step model. The main point about refreezing is that new behaviour must be, to some degree, congruent with the rest of the behaviour, personality and environment of the learner or it will simply lead to a new round of disconfirmation (Schein, 1996). This is why Lewin saw successful change as a group activity, because unless group norms and routines are also transformed, changes to individual behaviour will not be sustained. In organizational terms, refreezing often requires changes to organizational culture, norms, policies and practices (Cummings and Huse, 1989).

3.6.2. Kotter’s change model.

Building on Lewin’s three-step change model, John Kotter (1996) of Harvard University developed a more detailed approach for managing change. Kotter began by listing common errors that leaders make when attempting to initiate change. These included the inability to
create a sense of urgency about the need for change, failure to create a coalition for managing the change process, the absence of a vision for change, failure to effectively communicate that vision, failure to remove obstacles that could impede the achievement of the vision, failure to provide short-term achievable goals, the tendency to declare victory too soon, and failure to anchor the changes into the organization’s culture. Based on these errors, Kotter proposed an eight-step process for managing change. Kotter’s first four steps represent Lewin’s “unfreezing” stage. Steps 5 through 7 represent Lewin’s “moving” stage. The final step corresponds to Lewin’s “refreezing” stage. Thus, Kotter’s contribution provides leaders and change agents with a more detailed guide for managing change successfully.

3.6.3. HSE change model.

Irish Health Service Executive believes that change is a constant feature of health and social care service delivery. The ongoing change within the Irish health system impacts upon almost every aspect of our culture: the way we work, the way we relate to each other and how we plan and deliver services for the benefit of patients, services users and local communities (HSE 2008). The change model was developed in 2008, with the aim of improving the experience of patients and service users, help the staff and teams play a meaningful role in working together to improve services and promote a consistent approach to change across the system. This model is based on an organizational development approach which places a strong focus on the people aspect of change. It is combined with project management, which brings structure and discipline to the process.

3.7. RATIONALE FOR SELECTION OF THE CHANGE MODEL

I have selected HSE Change model as a tool for my organisational change management project. It is based on sound up-to-date research and best practice in change management and
organisational development. It also incorporates approaches to change that are already in existence within the HSE and other health service organisations, including project management and agreed partnership based approaches to change (HSE 2008). This guide has been developed to help you to succeed in bringing about real improvement by setting out a step by step model to planning, managing and implementing change. It places a particular emphasis on communicating and engaging with stakeholders, for example patients, service users, local communities, staff, teams, trade unions, and it sets out practical tools to help you in doing so. By approaching change as a continues and cyclical process with between step flexibility, The HSE model itself shows all of the stages and steps are interrelated and influence each other.

The Change Process

![HSE Change Model](image)

**FIGURE 2: HSE CHANGE MODEL**
The four stages of HSE change model includes the following

- Initiation
- Planning
- Implementation
- Mainstreaming

The application of these steps to change management process is described as follows.

3.8.1. INITIATION

The key task in this stage is preparing to lead the change. This stage focuses on the need for change and the degree of urgency, identify stakeholders, assess the readiness and capacity for change, assess organisational culture and opportunity for change, and set objectives and find out the resources. The purpose this early preparation and scoping stage is to create readiness and considered case for change, to establish sense of shared responsibility and to scope out a solid foundation for successful change (HSE 2008).

3.8.1.1. Drivers and resisters

The initial stimulation for this change initiative was the author’s special interest in quality improvements in dementia care. Moreover as a nurse by profession author believe that the author has an ethical obligation to appropriately treat the patient’s pain. The interest was further enhanced by an unannounced visit by HIQA last year; many recommendations were made in relations to pain assessment and management. Author got an opportunity to announce this change in a staff nurse meeting. The main opposing factors/ resistance include the potential for change fatigue. Resistance from the staff side were due to perceived fear of increased work load, low tolerance to change, habit and organisational culture.
3.8.1.2. Identification of stakeholders

Health service is a complex, multi-sectoral and multi-professional environment. Mapping out key stakeholders and influencers, and engaging with them on a formal and informal basis, will help to get an early sense of the opportunities and possible concerns for all of these groups.

A stakeholder analysis (appendix 1) was carried out in which stakeholders were mapped on the basis of their interest, potential risk and involvement in the change. The input of all stakeholders will influence and shape the content and nature of change and the approach being adopted. It will also help to identify the critical mass of support required for the change to succeed and improve the communication and engagement required for each group (HSE-2008).

Based on stakeholder analysis a new communication pathway developed to improve the communication among the staff members. They include

- Staff nurse has to carry out pain assessment on admission, regular basis (if they are in pain or showing signs and symptoms)/or every 3 monthly (if no pain) and report to line managers and GP.
- A complete pain care plan has to be maintained immediately after identification of pain and a complete hand over to be given end of each shift.
- Incorporate nurses to GP rounds and notify GP if the resident is in pain.
- Staff nurse has to incorporate other multi-disciplinary team members (physiotherapist, occupational therapist and nursing assistants) to identify and assess the pain and regular feedback to be given to each member.
3.8.1.3 Readiness and capacity to change

This stage assess how ready, people are to undertake what is required, and to identify the most appropriate ways of supporting people through the change. Readiness and capacity are influenced by factors internal and external to the individual and organisation. Readiness to embrace change is closely aligned to organisational culture, and the nature of relationship between people, teams, services and agencies. Capacity for change relate to level of organisational commitment to resourcing the change and to ensuring that staff have the knowledge, information and skills to take responsibility for action (HSE 2008).

Readiness capacity assessment carried out (appendix 2) among the stakeholders by using a Readiness Capacity assessment chart (Beckhard and Harris 1987: 63). A high rating was scored on most areas of capacity for change while a medium rating was scored on some areas of readiness for change. The Author believes the deficit in readiness arouse from fear of increased workload and staff resistant to leave their comfort zone because of low tolerance to change.

3.8.1.4 SWOT Analysis.

A SWOT analysis was carried out (appendix 3) with one of the CNMs in author’s organisation which help evaluate, especially the weakness and strength of the change process. SWOT, is an acronym from its principal components: Strength, Weakness, Opportunities and Threat. (Glaister & Falshaw, 1999). In its simplest form, Kay defines the SWOT analysis as “simply a list” (1993, p. 268). In itself, it is not an analysis but, as a tool, it can aid in effectively performing a broad analysis. Bullington (2005) agrees SWOT analysis can be effectively used in an early environmental analysis due to its categorical structure. “Environmental scanning” and “situation analysis” are other terms often substituted for SWOT analyses, and help to describe what a
SWOT analysis does, i.e., define what strengths can be used to build upon; what weaknesses should be covered; what opportunities can be captured; and which threats should be defended against.

**3.8.1.5. Force field analysis**

Force field analysis is a time-honoured, problem solving and action panning technique first described by psychologist Kurt Lewin in the 1950s (Lewin 1951). Peer Senge has noted that leader's effectiveness is largely depend on the accuracy of his/her mental map on the change environment (Senge 1990). The goal of force field analysis is to help leaders and stakeholders identify, document and understand those force likely to influence plan implementation. The technique assists change agents in developing effective action plans that are multi-dimensional and focused on high leverage issue. (Bailey 1994, Hurt 1998). It should be noted that force field analysis can be used interactively during multiple phases of the planning process. Prior to actually developing an action plan, the technique can be used to initially diagnose a problem or action plan. A force field analysis was carried out in a stakeholder meeting, which was held during the initiation phase (appendix 4).

**3.8.1.6. Cultural and political factors**

Culture represents the personality of an organization, having a major influence on both employee satisfaction and organizational success. It expresses shared assumptions, values and beliefs and is the social glue that holds an organization together (Trevino & Nelson 1999, p. 207). The cultural and political factors can have a positive or negative impact on the success of the change (HSE 2008). Attending the reality of internal politics – what is going on within the organisation is an essential part of managing change. The culture of organisation and relationship between
people at all levels are important and this knowledge should be used in a constructive way to plan or monitor ongoing developments.

Handy (1985) – philosopher, educator, economist and business guru – identifies four cultures (i.e. power, role, task and person) within the organisation. Each type has its own unique characteristics, each can be effective, and each can exist along with the others.

Organizational culture is defined in terms of the sociability and solidarity dimensions as proposed by Goffee and Jones (1998). Goffee and Jones (1998) categorized organizational culture into four main types based on two dimensions: sociability and solidarity. Based on these two dimensions, Goffee and Jones suggested that there were four main types of corporate culture, namely the communal culture, fragmented culture, networked culture and mercenary culture. In this framework, culture is a community or the way in which people relate to each other.

A lot of socialisation took place during this phase, especially tea and the lunch break time, during the time of handover, staff meeting, smoke break time etc. A cultural analysis was carried out in authors organisation, base on Goffee and Johns cultural analysis tool, there is an existence of fragmented culture with low sociability and low solidarity. Effort made to improve the communication among the staff and help the staff for role identification. Secondly, new standard and procedure developed to improve the communication among the staff. Moreover new policy developed for recording and reporting.
3.8.1.7. **Assessment of change impact**

At this point in the process an assessment of impact (appendix 5) can only be done at the generalised level. However, the initial impact analysis is a powerful way to gain insight into the amount of attention, planning and resources the change will require. It also assists in taking a whole system view of the change process, and assist people to generate options and explore possibilities (HSE 2008).

3.8.1.9. **Objectives and outcomes**

Objectives are specific statements of the outcome to be achieved. It is important to be able to communicate clearly the intended objectives and outcomes of the change in line with its vision and core purpose (HSE-2008). This will help people to engage in the process and will build commitment for the change. The objectives need to be specific, measurable achievable, realistic

**Source:** Goffee and Jones (1998)
and timed (SMART). The SMART objectives are as following.

1. To conduct a pre-test among the staff to get a feedback of staff awareness about best practice approach to pain assessment in dementia during the time of awareness programme.

2. To update the pain scale in my organisation based on literature and also conduct a staff awareness programme about the best practice approach to pain assessment in dementia during my implementation phase.

3. To conduct a systematic review of my study to evaluate the improvement in staff knowledge level about how to use the pain scale and best practice approach to pain assessment during the evaluation stage of my study.

**Resource requirement**

Change effort needs to be adequately resourced to be successful (HSE 2008). It should be assessed what type of resources (people, financial, technological, infrastructural) are needed for success of the change and where are these resources currently available. In this project, the main resources were people, time and utilised technological and infrastructural resources of author’s organisation.

**3.8.1.10. Business case for change**

The business case will enable the leaders to get preliminary board approval for proceeding with the change effort. It also provides a reference document and should be used to continually proof and track progress of the change project. The business case should also be communicated in a way that enables staff and their representatives to see their role in the overall change effort (HSE 2008). Approval received from the top management level to continue with change and due consideration was given that all stakeholders were clear on their role in the change project.
3.8.2. PLANNING

The purpose of this step is to further increase commitment for the change across the system, build a shared vision for change and engage in activities that all increase readiness and capacity to embrace the requirement of new future (HSE 2008). It also aims to create a critical mass of support and readiness by engaging staff and key stakeholders in creating a shared vision for the future. This phase include

- Building a commitment
- Developing the detail of the change
- Developing the implementation plan.

3.8.2.1. Building a commitment

Although people are the most important factor in making change, however, they are also the most difficult element to deal with (Linstone and Mitroff, 1994). Therefore, managing the human part of the organization becomes a major challenge in handling change processes in the organization as it involves values, preferences, and attitudes toward a particular activity. Attitudes, for instance, are difficult to change as people are generally more comfortable with what they have learned or knew due to stereotyping, fear of taking risks, intolerance to ambiguity, and possibly the need to maintain tradition (Dunham, 1984; Carnall, 1990). Iverson (1996) found that an employees’ acceptance of organizational change increases with organizational commitment, a harmonious industrial relations climate, education, job motivation, satisfaction and security.

In this stage, the key task was to clearly communicating the vision and put maximum effort to make the staff understands that the change is underway. This process of translating and
adapting the vision brings a greater sense of reality for the staff at local level. Managers were tried to work with staff and other key stakeholders to help them to understand the vision in a meaningful way.

The author observed that arranging a meeting with team members, and explain to them, what happened and what is going to happen will inspire their desire to change. Author organised team meeting regularly and findings were subsequently presented to the team members. The main purpose of the meeting was to assess the readiness for change, test their knowledge, attitude and awareness about the change. A business case of change was adopted by group.

3.8.2.2. Determine the detail of the change

The purpose of this step is to undertake the detailed design of organisational, service and cultural changes that will enable the organisation to achieve its vision. This stage helps to prepare the organisation for implementation (HSE 2008). Another meeting was held with team members to communicate the details of change. A problem solving approach was adopted and details of future stage discussed.

3.8.2.2.1. Process mapping.

Process mapping is also known as system task analysis, process task analysis, process diagramming, and work mapping (Langdon, 1999, 2000; Marrelli, 1998; Siever, 1993; Swanson, 1994; West, 1997). Visual description of old and new care pathways displayed in ward (appendix 6 & 7). Obviously, effect was huge, it depicts about the current and future pain assessment methods and also indicated that the sequence of actions the performers should take and how they can improve.
3.8.2.2. Change management team

It was in this phase a change management team developed. The team comprise of a CNM and 2 staff nurses. All the new decisions, which were taken by the change management team, also discuss with DON before implementation. The two new pain assessment tool and staff awareness programme also discuss with DON.

3.8.2.3. Developing implementation plan

More detailed design of the organisational change was undertaken in this stage. This phase helps to prepare the organisation for implementation. This step goes in to detail about the specific changes need to accomplish the vision. The detailed design will address the impact on strategy, policy, structure, processes, culture, people and working relationship. The staff from all level of organisation will involve and they are encouraged to voice their thoughts and concerns. A manager can empower others by including them in problem solving. Many managers today seek quick-fix solutions to chronic problems, and they fail to see the long-term consequences of their short-ranged decisions (Covey 1991).

3.8.2.3.1. Scope of change

The start date (1/1/14) and the implementation time frame (four week) was communicated among the staff. The change will be focused on the update the pain assessment scale and conduct a staff awareness programme regarding best practice approach to pain assessment in dementia. We were greed to conduct a staff awareness programme in the initial stage itself. The intention was to give a good introduction about the new pain scales (appendix 8 &9) along with the best practice approach. The main scope of awareness programme was to empower the staff in best practice approach to pain assessment in dementia.
3.8.2.3.2. **Sequence of change step**

During the group discussion, the main concerns raised by some of the group members were scheduling the time and venue of the programme. Finally we agreed to arrange the programme in a two different occasions in order to accommodate all staff. We also planned to prepare hand out for all staff members to attract their attention. It was planned as a 30mts programme and the end of the programme we planned to evaluate the staff with Kirkpatrick’s 4 level model of evaluation tool. So along with staff handout we prepared questionnaire for evaluating staff. This was also discussed with DON and agreed.

3.8.2.3.3. **Resource required**

The existing staff and equipments were utilised. The handout (appendix 10) was prepared in the organization itself. Some of the valuable journals were collected and given to staff for literature support.

3.8.3. **IMPLEMENTATION**

This stage focuses on implementing and monitoring implementation or project plan to ensure that it is meeting its purpose. In this phase the new ways of working are agreed and being implemented and that inappropriate model of working are discontinued. Leaders must actively attend to what is actually happening in the organisation as it is changing. Changing an organization is not a simple process, often difficulties are encountered within such a change process. Research has shown that over 70 percent of the change programs in organizations do not achieve the intended goal (Hall et al. 1993; Bashein et al., 1994). Boonstra (2004) criticizes typical explanations given for these failures in that they pay insufficient attention to the complexity of the change process itself.
The team made the list of staff attending both session of awareness programme and all staff members informed. The second programme was organised in the following week. Before starting the awareness programme, a pre-test (appendix 12) was conducted in order to test their knowledge. All six staff nurses were attended the programme. A few of them were concerned that The MOBID pain scale is complicated and difficult. The concern was successfully addressed from the class itself by both the change leader and at the pear level. After both scheduled session post-test (appendix 13) was conducted to assess improvement in their knowledge. Other than these two tests, participants were requested to fill up a “happy sheet” (appendix 11) to assess what the participants felt about the project or programme.

The awareness program was completed in two weeks. Staff found to be very confident and they started following the new practice. Most of the nurses started doing the three monthly pain assessment for all residents along with other assessments, which was not done before. For all new admissions, whether residents were in pain or not, the pain assessment becomes mandatory. The occupational therapist and physiotherapist also expressed their delight. A positive feedback received from GP, DON and some family members. However, some nurses showed their reluctance; especially those are working in the busy unit, complained that they are not getting enough time to do the assessment for all residents. This resistance was successfully addressed by the change leader by making some adjustment with scheduled work. The new best practice approach and the pain scale given to DON to make necessary changes in home pain assessment policy. Regular feedback on the change management project was informed to senior management team.

Because change typically takes time to implement, ways of sustaining the momentum and energy for the change over time are needed. Leaders should plan to sustain energy for the
change and to see it through over the long term, modifying action as new needs arise. The change leader always interacts with staff aimed at providing support, and encouraging expression of alternative opinions. All opinion, positive or negative, was given due consideration. Negative reactions were quite minimal-especially regarding lack of time in busy ward-all address with an effective ways. Plenty of appreciations received from, family, staff and other multi-disciplinary team members.

3.8.4. MAINSTREAMING

The purpose of mainstreaming is to focus attention on the success of the change effort and on integrating and sustaining the new ways of working and behaving and also support the new skills and practices in our everyday activities. This stage also focuses on mechanism for evaluation and continuous learning in order to increase readiness and capacity for ongoing service improvement (HSE 2008)

3.8.4.1. Making “the way to do our service”

To make a new practice,” the way to do our business” (HSE 2008), the change leader approaches three ways mainly:

- Acknowledge success and achievements
- Support integration of change
- Ensure decision making process support the change.

Under the first approach, at all stages of change process, the change leader provided opportunity to celebrate the success, particularly when key milestones are reached. In this phase, the change leader should discuss with key stakeholders, how the new work practice was
linked to on-going practices. In authors organisation, this project created a big impact. First of all, author believes, we were able to improve the quality care in my organisation. Staffs were able to identify and measure the pain in an effective way. They were empowered with new skills and knowledge, and author believes this will enhance their professional confidence and increase their job satisfaction, that overall will help their career progression.

In the second measure was taken to support the staff to embed the changes into their everyday activities and behaviours. In this phase all stakeholders should understand how the overall organisation now. The change leader personally met all the six staff nurses and offered their support to get along with new changes. The key stakeholders were stayed in the unit with staff nurses to support them. Moreover to know how each part of the system functions and effort made to pay attention to strengthening the relationship and connection in the system.

To embed the change, it is also essential that to review the change process and support the new behaviours and mindset, to make the changes the way we do our business. Clear communication and engagement process also need constant attention to ensure effectiveness. Clear line of responsibility and accountability for decision making are also essential elements. The change leader written and submitted a summarised report to DON. The change leader was able to convince the nursing director to adhere the new practice as a part of regular performance. Furthermore, the change leader successfully convinces DON to update the performance review and appraisal system at least yearly basis, for nurses for further professional development. Each stakeholder role for decision making was clearly identified and ensured all aware about their role. The role culture, more familiarly known as a bureaucracy, is the category in which most hospital organizations fall. The strength of role organizations resides in its pillars, its functions or specialties (Handy 1985, p. 190).
3.8.4.2. Evaluation and learning

To embed the practice further, it is essential to carry out review the change process. The purpose of this step is to put in plays ways to evaluate and learn from the way the change process was designed and implemented. The primary goal of evaluation was to identify how successfully the change was implemented, is there any necessary adaptation needed for further improvements. Due consideration was given for section of evaluation tool, its reliability and validity. Evaluation was conducted in broadest level. The detailed evaluation will be discussed in next chapter.

3.9. SUMMARY

This chapter described the successful change management happened in author’s organisation with the help of HSE change model. In this chapter, a detailed discussion done on, initiation, planning and implementation of change process. The main resources for article include, the Royal College of Surgeons in Ireland (RCSI) library, mainly CINAHL and Emerald and also from Google scholar.
CHAPTER 4
EVALUATION

4.1. INTRODUCTION
Evaluation is any activity that throughout the planning and delivery of innovative programmes enables those involved to learn and make judgements about the starting assumptions, implementation processes and outcomes of the innovation concerned (Stern 1990). Training in itself has no intrinsic value. It is not an inherently good or bad thing. Its value lies in the extent to which trainees are able to acquire, apply (transfer) and retain enhanced or new knowledge, skills and attitudes in the workplace. The only way to investigate this is to evaluate. The result evaluation should be an integral and an ongoing element of the design and delivery of employer-led training programmes (Wang and Wilcox, 2006). However for most organisations this is not the case (Berge, 2008).

Evaluation involves the systematic collection of information about activities, characteristic and outcomes of an activity or action, in order to determine its worth or merit (Dart et al 1998). Through the identification of the highlights and lowlights of the project, evaluation draws conclusions which can inform value decision making, assist to define future projects and policies (Patton 1997). Training programmes are an essential feature of organisational life (Sandi and Robertson, 1996). Training initiatives are widely acknowledged to be a salient feature of the competitive organisation’s corporate strategy and, in times of great change, learning is the key skill (Tennant et al., 2002). Employees, managers and organisations rely on training as a solution to enable issues to be resolved (Hale, 2003). In this chapter the author likes to address the evaluation of the change project.
4.2. EVALUATION TOOLS AND RATIONALE FOR SELECTION

Various tools and methods are available for the purpose of evaluation. The first documented instance of evaluation of a formal learning programme took place in 1792 (Hogan 2007). Donald Kirkpatrick’s four level criterion model of evaluation, which still dominates in the field, was published in 1959. Author like to select Kirkpatrick training evaluation model. A method to assess the value or impact of learning is to compare the activities and outputs against a recognised industry best practice model. One such model is the Kirkpatrick training evaluation model (Turner, 2006). This simple yet effective evaluation system presents four levels of attainment. At Level 1 success of the training is assessed in terms of satisfaction and planned action. Level 2 requires the measurement of improved skills or knowledge. Level 3 captures the application of skills and knowledge “back-on-the-job”. Level 4 measures the resulting changes or improvements in the business from this applied knowledge.

Learning outcomes and affective reactions remain the most common means of assessing workplace learning may account for the enduring popularity amongst practitioners and some academics of Donald Kirkpatrick’s 1959 four-level criterion approach to evaluation (Aguinis and Kraiger, 2009). Phillips (2002) extended the Kirkpatrick model to include the concept of return-on-investment (ROI). Here the business impacts are converted to a monetary value and compared to the cost of investment in the training and all other contributory factors. Author doesn’t like evaluate this area because it is too subjective and can’t evaluate in a short period of time. A valid assessment of HRD outcomes cannot be readily or effectively achieved because such an assessment will be too subjective and requiring too many assumptions to be made (Campbell, 1994; Edwards et al., 2003).
### 4.3. KIRKPATRICK’S MODEL OF TRAINING EVALUATION

<table>
<thead>
<tr>
<th>LEVEL NUMBER</th>
<th>LEVEL TITLE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reaction</td>
<td>Measures participants’ reaction to and satisfaction with the learning experience</td>
</tr>
<tr>
<td>2</td>
<td>Learning</td>
<td>Measures the learning and improvement in knowledge and skills</td>
</tr>
<tr>
<td>3</td>
<td>Behaviour</td>
<td>Measures changes in on-the-job behaviour and progress with planned actions</td>
</tr>
<tr>
<td>4</td>
<td>Result</td>
<td>Measures the changes in business impact. Has the training helped towards the operational objectives?</td>
</tr>
</tbody>
</table>

Source: Kirkpatrick (1998)

*TABLE 2: KIRKPATRICK’S TRAINING EVALUATION TOOL*
4.3.1. Phase 1. Reaction

The first category or level in Kirkpatrick’s model is the “reaction” or feelings that participants in a training program have toward the actual program. The reaction may be defined as how well the trainees liked a particular training programme. Evaluating in terms of reaction is the same as measuring the feeling of the conferees. It refers to the emotional responses of trainees to the training programme and therefore does not take into account any measure of learning. In this measuring what the participant felt about the project or programme. This level measure how the trainees reacted to the training typically by a “happy sheet”. Feedback form based on subjective personal reaction to the training experience. It can be done immediately the training ends.

This reaction assessment was done after the training programme; a “happy sheet” was already prepared in the implementation phase itself (appendix 11). Every member felt the training was
adequate. All agreed that the training was worth their time and the session accommodate their professional learning style. They were also happy with trainer, presentation style, material used for the presentation. Moreover, 100% appreciation received for the time scheduling time and the selection of venue.

4.3.2. Phase 2. Learning

Learning is defined as what principles, facts and technique were understood and absorb by the conferees (Kirkpatrick 1959). The second category in Kirkpatrick’s model is “learning” and is concerned with knowledge outcomes, or ideas, information, and approaches from the training program that are understood and retained by trainees. Learning evaluation is a measurement of increase in knowledge or intellectual capacity from before and after the learning experience. That means methodologies and training acquired by trainees without considering their job related application. It’s often helpful to measure these areas both before and after training. So before training commence, test your trainees to determine their knowledge, skill level and attitude. Once training is finished, test your trainees a second time to measure what they have learned, or measure learning with interviews or verbal assessments.

Before the training session, a pre-test was conducted (appendix 12). Among the six staff nurses, four of them were answered very well and two of them were came under ‘good’ level and all staff nurses agreed both of these pain scales were better than Abbey pain scale and they all happy to use them. The reason behind this suggestion was that, the abbey is only used for a patient who is not able to talk and the rating is only based on nurse’s perception of pain, no patient involvement. A post test was conducted after the training session (appendix 13), four of them came under excellent category and remaining two were very good.
FIGURE 6: PRE-TEST (KNOWLEDGE LEVEL OF Nurses BEFORE TRAINING)

FIGURE 7: POST-TEST (KNOWLEDGE LEVEL OF Nurses AFTER TRAINING)
4.3.3. Phase 3. Behaviour

The Level three captures the application of skills and knowledge “back-on-the-job” Level three, or behaviour, relates to the real usage of new principles and practices learned by trainees to modify and improve their behaviour and performance at work. Kirkpatrick identified “behaviour” as an outcome. This level is concerned with the actual on-the-job application of learned ideas, information, and approaches from the training programme. At this level, you evaluate how far your trainees have changed their behaviour. Observation and interview methods were adopted to evaluate this stage.

4.3.3.1. Observation method.

It is a systematic process of recording the behavioural pattern of people, objects and occurrences as they are witnessed. It was very difficult to observe all six staff nurses, because of
the tight work schedule. Among the six nurses, randomly selected four of them for observation. Closely observed them over four weeks. Each team members felt that communication was adequate. All four staff nurses were followed best practice approach for pain assessment. In all units GP rounds became very active, nurses were very happy to participate in GP round along with CNM. It is still not evaluated how the staffs were using a pain scale in the workplace, because the pain scale has to be updated in the ‘Epic Care’ system before start using it, for that author need technology support. Pain scale already submitted to DON and still waiting to update it.

4.3.3.2. Interview method

In the interview, knowledge is created inter the point of view of the interviewer and interviewee. The purpose of the qualitative research interview is obtaining a qualitative description of life world of the subject with respect to interpretation of their meaning (Kvale 1996). Here the change leader conducted an informal interview with all the staff nurses, to get their feedback, opinion and suggestions about change project and its outcome. The change leader met most of the staff nurses personally and some of them contacted by telephone. The majority of the respondent expressed their satisfaction; a few expressed their opinion in such a way that self-report of pain is the best way to assess the intensity and severity of pain. But in the case of dementia, it is not possible, so they were also happy to use the pain assessment tool.

4.3.4. Phase 4. Result

Level four measures the resulting changes or improvements in the business from this applied knowledge. This level entails the impact of training on, for example, costs, productivity, quality or morale, increased employee retention and satisfaction, reduce in number of complaints, reduce wastage depending on the desired results of the training.
For result evaluation, the change leader done an audit on staff and family complaints, according to the audit result, there is a satisfactory reduction in staff and family complaints. Also change leader personally met each staff members, to identify their satisfaction level. Staffs were generally agreed that this project made a good impact on pain assessment in the organisation. They also agreed that they are very happy to follow the best practice approach for pain assessment.

4.4. SUMMARY
This chapter provides an overview of an evaluation of a change management in a health care setting, author adopted Kirkpatrick’s four levels of staff evaluation tool to evaluate the change management. It is very evident that change has led to an improvement and all the objectives of the change project were met. The main resources for article include, the Royal College of Surgeons in Ireland (RCSI) library, mainly CINAHL and Emerald and also from Google scholar.
CHAPTER 5
DISCUSSION AND CONCLUSION

5.1. INTRODUCTION

The change project was designed to empower the staff awareness in relation to pain assessment in dementia and update an existing pain assessment tool based on literature support. The rationale for the selection of the project, in depth review of literature, planning, implementation and evaluation phase of the project have been described in the previous chapter. This chapter will provide a brief overview of strength and weakness of this project, followed by future recommendations to author’s organisation.

5.2. STRENGTHS OF THE PROJECT

5.2.1. Scope of the project

Treatment and care should take into account each persons individual needs and preference. This project offers best practice advice on pain assessment of people with dementia and on support for nurses. There is a broad consensus that the principle of person- centred care underpin good practice in the field of dementia care and they are reflected in many of the recommendations made in the project. The core aim of this project was to draw a care pathway for pain assessment in dementia and help the staff to walk through this pathway. Author also paid attention on not to make a huge change in the culture of the organization or not to take staff far away from their “comfort zone” as this will develop a huge resistance to change.
5.2.2. Drivers for change

The health act 2007 and HIQA regulations made significant changes in residential care setting and care of people with dementia. HIQA made emphasis on treat the elderly with respect and dignity and also provide support on evidence based practice and continues quality improvement in the organisation. At this point it is inevitable to comply with best practice guideline and benchmarking the policy. This type of scenario often found in organisational structure described by Mintzberg. According to his concept, the national and international operator's plan sectoral structures and strategies, summarizes information and evaluates performance.

![Mintzberg's Model of an Organisational Structure](image)

FIGURE 9: MINTZBERGE’S MODEL OF AN ORGANISATIONAL STRUCTURE

5.2.3. Smart objectives

Objectives are the activities you undertake and the services you offer to bring these changes about. Or the objectives are specific statements of the outcomes to be achieved (HSE change model). The key components of the author's objectives were SMART (Specific, Measurable, Attainable, Relevant and Timely). They provided a framework for organising the project and ensured that the designed programme goals and objectives were achieved. Objectives helped to design each phase of the project and help to focus on the on the project during the time of
change.

5.2.4. Support from key stakeholders and management.

Managers like everyone else in organisational settings, are continually striving to make sense of numerous crosscutting and conflicting goals and purposes. Managers and non-managers alike constantly have to make and remake bargains, exert power, resist power, cope with conflicts of interest and negotiate understandings with others to make sure that the goods are produced or services provided to a level and quality that enables the organisation to remain in existence (Watson, 2005, pp. 2-3). Author got great support from the management side to carry out the project in an effective way. They helped to overcome the resistance to some extent.

5.2.5. Resources availability

In this project, due consideration were given to the use of existing resources. The main resources were the staffs and their time. Priority was given to proper utilisation of available resources (staffs), allocation of available resources and scheduling their time.

5.2.6. Contribution to organisation

The change project was carried out in an active dementia unit. This study has huge potential to improve the quality of life of the patients. In today’s world, number of dementia patients increasing day by day, however, there is not much robust research done into the pain assessment of such patients. This study draws insight into the best practices that can be accomplished for improved pain assessment. This project also aims to provide an opportunity to re look at our current practices in this area and improvise them.
5.3. WEAKNESS OF THE PROJECT

5.3.1. Time pressure

The SMART objectives were time bound. The change leader was at times struggling to finish some stages of the project in the right time, especially the evaluation stage. It is still not completed due to lack of availability of technical support team. This is due to tight work and study schedule of the author, moreover tight work schedule of the staffs who were directly involved in the project.

5.3.2. Lack of prior experience of the change management

No prior experience in change management for similar scenario in my organization. Success totally depends on the leader’s credibility and persuasive communication skills in addition to technical knowledge and logical or analytical ability. However, this potential weakness didn’t make much effect on the project.

5.3.3. Expert power and position of the change leader

Expert power is based on a knowledge differential between the leader and the target person. Rational persuasion is most effective when the target person shares the leader’s objectives. To be granted expert power, followers must perceive the power holder to be credible, trustworthy, and relevant (Luthans, 2011). From the personal perspective, lack of prior experience in change management was appeared as a threat in the initial stage of the project.

5.3.4. Resistance

Many authors stress that the reasons for the failure of many change initiatives can be found in resistance to change (Lawrence, 1954; Maurer, 1996; Strebel, 1994; Waddell and Sohal, 1998,
Resistance affects the speed at which an innovation is adopted. Resistance to change introduces costs and delays into the change process that are difficult to anticipate but must be taken into consideration (Ansoff, 1990, Lorenzo, 2000). At the beginning of the change management, there was lots of confusion, anger, depression, testing from the staff side, which delayed the project to some extent. When a change is introduced in this environment, with a lot of discussion, employee involvement, staff training, communication and coercion, resistance to change is minimized. Resistance is also minimized if there is a wide-spread belief that a change is needed.

**MINIMIZING RESISTANCE TO CHANGE**

![Diagram of minimizing resistance to change](image.png)

**FIGURE 10: MINIMIZING RESISTANCE TO CHANGE**

### 5.3.5. Small sample size

Though it wouldn’t affect the project adversely, in the initial phase, the author planned to accommodate all staff members, family and residents in the organization. When it came to the reality, due to ethical issues, the change leader decides to involve only the staff members who
have directly involved the study. The sample group was very small in size and data collected and
evaluation done in a small group.

5.4. RECOMMENDATIONS FOR FUTURE IMPROVEMENTS

On the basis of lessons learned from this project, there are a few recommendations for future
improvements. Author’s organization is a 100 bedded nursing home, run by the private sector.
The nursing assistants also play a vital role in the Activities of Daily Living of the residents.
Because of that, they are also able to identify the pain presences like nurses. I would
recommend, if they are also included in pain assessment that would be another great movement
in the area of pain assessment. In the long-term care setting, the certified nursing assistant is a
key health care provider who has been shown to be effective in recognizing the presence of pain
(Fisher et al., 2002; Mentes et al., 2004). Secondly, I would recommend providing more training
for nurses and nursing assistance, to rule out the root causes of pain in dementia (eg;
constipation, pressure ulcer, urinary tract infection and falls) and how to prevent and manage
them. Alongside the need for an enhanced understanding of pain mechanisms, there is also a
requirement for healthcare professionals to gain the necessary skills, knowledge and expertise to
enhance pain assessment and management practices (Brown 2011). Thirdly, it would be a good
advancement in nursing practice, if one or two nurses get practice in prescribing medications. It
will result a huge impact on the way we manage the pain, especially the GPs are off sight and
the stress nurses may experience to manage pain. In 2007, law in Ireland was changed and
make it possible for the nurses and midwife prescribes medications. Fourthly, in long-term care
facilities, pain management is complex because dementia, delirium, and other reasons for
residents’ altered communication ability is a significant barrier to pain assessment. My
recommendation is to explore the status of implementation of pain assessment as a fifth vital
sign. To elevate awareness of pain treatment among health care professionals, the American Pain Society (APS) created the phrase “Pain: The Fifth Vital Sign.” Assessing pain as a fifth vital sign is currently recommended as the “gold-standard” by all national palliative care organizations. Fifthly, organize staff appraisal for every six months. The main motivation is to make working life productive, rewarding, healthy and enjoyable. And also enable the managers to diagnose any deficiency or improvement in line with set performance standard. Bhattacharya (2008) argues that the appraisal process is a joint responsibility of personnel specialist who prepares and administers the evaluation instrument and the line manager who designed job assessment areas and instruments to conduct the assessment (appraisal) and forward the scores to the personnel management department for the record management purpose. The measurement of performance or appraisal is a vital instrument for ensuring employees’ performance improvement (Caputo & Roch, 2009).

5.5. CONCLUSION.

Pain in older people is a common problem, pain can have a significant effect on an individual’s quality of life, and may also decrease their ability to function effectively. The aim of this project was to empower the staff awareness about a best practice approach to pain assessment in dementia and update the pain scale based on literature support and thereby improve the quality of care. The author had described how the change management project was implemented successfully; using HSE change models along with some management tools such as SWOT analysis, force field analysis and stakeholder analysis, etc. On top of that, the author explained, how the evaluation was carried out with the help of Kirkpatrick’s staff evaluation tool and the result. Also author reviewed the literature on this topic, and a detailed critique was done in the
various areas of pain assessment. Finally, in conclusion, the author explained the strength and weakness of the project and suggestions were given for future improvements. All the team members were agreed that, it was a very valuable learning experience and they were very happy that they were also able to be a part this project.

“Everyone in healthcare really has two jobs when they come to work every day!

To do their work and to improve it.”

Batalden, P.B & Davidoff, F., 2007
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# APPENDIX 1

## Stakeholder Analysis Plan 2013

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>PROBLEMS</th>
<th>INTEREST</th>
<th>POTENTIAL RISK</th>
<th>INTERACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>Visits only once in a week, so inadequate treatment for some due to lack of time. Payment is the issue for private Physiotherapist</td>
<td>Increase hours of physio visit or arrange community physio service</td>
<td>Not able to address or overcome physical pain on time. Patients are not able to return to activities or achieve personal goals.</td>
<td>Directly</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>Finding difficulties to manage care staff, not following the instructions??</td>
<td>Follow up, improve interaction with care staff, encouragement and arrange staff awareness programs</td>
<td>Increase in postural issues and seating problems. High risk of pressure sore</td>
<td>Directly</td>
</tr>
<tr>
<td>CNMs</td>
<td>No direct interaction with patient and insufficient idea about current issues.</td>
<td>Improve interaction with patients, staff nurses and health care assistance. Involve staff nurses during G.P. rounds</td>
<td>Lack of knowledge about current situations leads difficulty in managing problems in the future.</td>
<td>Directly/Indirectly</td>
</tr>
<tr>
<td>Staff nurses</td>
<td>Neglecting pain assessment/measuring pain for those who are not able to verbalize and cases with inadequate documentation</td>
<td>Pain assessment and measurement should be carried out on time when patients are showing any deviation from their normal behavioral pattern and treat their root cause of pain</td>
<td>Inadequate pain assessment &amp; measurement and poor documentation will affect patient safety</td>
<td>Directly</td>
</tr>
<tr>
<td>Health care assistants</td>
<td>Inadequate attention to patients with deteriorating condition and having deviation from normal behavior, not passing information on time, not properly caring out physio /OT orders coupled with poor documentation</td>
<td>Professional improvement</td>
<td>Patient safety</td>
<td>Directly</td>
</tr>
</tbody>
</table>
## APPENDIX 2

### READINESS AND CAPACITY ASSESSMENT

<table>
<thead>
<tr>
<th>Stakeholder group in the perspective of readiness and capacity to change</th>
<th>Readiness</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities for change</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>Overall readiness and capacity of the leaders to bring about effective change</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Level of responsiveness to the urgency for the change</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>The level of shared understanding for the vision for change</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>The level of focus on service users, communities and the local population</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>The effectiveness of communication processes both internally and externally</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>The orientation towards team working and working across boundaries</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>The levels of engagement and partnership working based on experiences to date</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>The culture of continuous learning and evaluation</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>The level of resources available to support the change. Consider factors such as people, financial, ICT, accommodation infrastructure</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>The capacity to balance stability and change</td>
<td>Low</td>
<td>Medium</td>
</tr>
</tbody>
</table>
# APPENDIX 3

## SWOT Analysis

<table>
<thead>
<tr>
<th>Strength (S)</th>
<th>Weakness (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Highly experienced and enthusiastic staff</td>
<td>✓ Lack of adequate resource/data available</td>
</tr>
<tr>
<td>✓ Strong support from the Director of Care</td>
<td>✓ Poor response from some of the patients when dementia progress, as they are not able to verbalize their feelings</td>
</tr>
<tr>
<td>✓ Support from the CNMs and staff nurses</td>
<td>✓ Difficulties with time management due to tight work schedule and competing priorities</td>
</tr>
<tr>
<td>✓ Ongoing follow up</td>
<td>✓ No prior experience in change management for similar scenario in my organization. So difficulty in getting a second opinion.</td>
</tr>
<tr>
<td>✓ An environment which facilitates close monitoring of staff.</td>
<td></td>
</tr>
<tr>
<td>✓ Strong support from physiotherapist and occupational therapist</td>
<td></td>
</tr>
<tr>
<td>✓ Strong rapport among the staff, where research is done</td>
<td></td>
</tr>
<tr>
<td>✓ Organizational policy encouraging such researches</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunity (O)</th>
<th>Threat (T)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ This study has huge potential to improve quality of life of the patients</td>
<td>✓ Resistance to change</td>
</tr>
<tr>
<td>✓ In today’s world number of dementia patients are increasing day by day, however there is not much robust research done into the pain assessment of such patients. This study draws insight into the best practices that can be accomplished for improved pain assessment</td>
<td>✓ Medication side effect and complications</td>
</tr>
<tr>
<td>✓ Staff would be empowered with new skills and knowledge; this study will enhance their professional confidence and increase job satisfaction. That will help their carrier progression as well</td>
<td>✓ Patient may addicted to some of the medications</td>
</tr>
<tr>
<td>✓ An opportunity to re look at our current practices in this area and improvise them</td>
<td>✓ Perceived beliefs of the staff and family</td>
</tr>
<tr>
<td></td>
<td>✓ Negative and fragmented organizational culture</td>
</tr>
</tbody>
</table>
# APPENDIX 4

## Force Field Analysis

**Proposed change**

To empower the staff awareness in pain assessment in dementia.

<table>
<thead>
<tr>
<th>score</th>
<th>Forces for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Staff awareness regarding pain assessment.</td>
</tr>
<tr>
<td>3</td>
<td>Improve the quality of care</td>
</tr>
<tr>
<td>3</td>
<td>Better assessment of pain</td>
</tr>
<tr>
<td>2</td>
<td>Increase patient safety</td>
</tr>
</tbody>
</table>

**Score**

<table>
<thead>
<tr>
<th>Forces against change</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

Total score = 12

Total score = 11
## APPENDIX 5
### PROJECT IMPACT STATEMENT

<table>
<thead>
<tr>
<th>Behavioural</th>
<th>HOW THINGS ARE DONE NOW</th>
<th>HOW THINGS WOULD BE IN FUTURE</th>
</tr>
</thead>
</table>
|             | Staffs are not aware the best practice approach to pain assessment.  
Not using the pain assessment tool and not communicating patient’s condition to line managers and GP. | Staff would be empowered with best practice approach to pain assessment and they ready to practice their new skills in the ward.  
The attitude and practice of staff in relation to using pain scale will change and they will start to use pain scale based on best practice approach |

| Structural | There is no policy or guideline in relation to pain assessment in dementia patient.  
Nurses are ultimately responsible for pain assessment but there is no pain assessment is being carried out if the patient is not verbalising their pain. | Best practice approach to pain assessment will be implemented to guide pain assessment.  
In future nurses will follow the best practice approach and assessment of the patient would be based on this new guideline. |

| Personal | In today’s world numbers of dementia patients are increasing day by day and I have a long maintained special interest in dementia care. | Through participating and co-ordinating this project, I would be able to enhance my knowledge and skills in pain assessment in dementia, at the same time I am doing the organisational change management, this will further enhance my management skills and knowledge. |

| Cultural | Staffs have approached this in different ways. The initial stage they have only a superficial awareness about the project and resistance from their side due to perceived fear of increased work load, low tolerance to change, habit and organisational culture. | Staff would be empowered with new skills and knowledge. They would be very happy with their new role and would be very to relook at our current practices in this area and improvise them |
APPENDIX 7

NEW CARE PATHWAY

Pain Assessment

- On Admission
- Change In Patient Condition
- Anytime Pain Suspect
- Every Three Month

Self Report Of Pain

- Look for behavioural signs of pain or discomfort

Investigate the root cause

Visceral / Somatic Pain
Neuroleptic Pain
Psychological/Psychiatric Pain

Diagnose Pain

Pain Assessment tool used

GP review
## Pain Assessment in Advanced Dementia Scale (PAINAD)

**Instructions:** Observe the patient for five minutes before scoring his or her behaviours. Score the behaviours according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing independent of vocalization</td>
<td>Normal</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cheyne-Stokes respirations</td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Repeated troubled calling out</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low-level speech with a negative or disapproving quality</td>
<td>Loud moaning or groaning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or inexpressive</td>
<td>Sad</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frightened</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>Tense</td>
<td>Rigid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distressed pacing</td>
<td>Fists clenched</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fidgeting</td>
<td>Knees pulled up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pulling or pushing away</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Striking out</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract, or reassure</td>
<td></td>
</tr>
</tbody>
</table>

(Total Score)

**Scoring:**

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

**Source:**

**PAINAD Item Definitions**

(Warden et al., 2003)

**Breathing**

1. *Normal breathing* is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. *Occasional laboured breathing* is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. *Short period of hyperventilation* is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. *Noisy laboured breathing* is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. *Long period of hyperventilation* is characterized by an excessive rate and depth of respirations lasting a considerable time.

6. *Cheyne-Stokes respirations* are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

**Negative Vocalization**

1. *None* is characterized by speech or vocalization that has a neutral or pleasant quality.
2. *Occasional moan or groan* is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. *Low level speech with a negative or disapproving quality* is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.

4. *Repeated troubled calling out* is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.

5. *Loud moaning or groaning* is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. *Crying* is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

**Facial Expression**

1. *Smiling or inexpressive*. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.

2. *Sad* is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. *Frightened* is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. *Frown* is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the
forehead and around the mouth may appear.

5. **Facial grimacing** is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

**Body Language**

1. **Relaxed** is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. **Tense** is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. **Distressed pacing** is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.

4. **Fidgeting** is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.

5. **Rigid** is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)

6. **Fists clenched** is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.

7. **Knees pulled up** is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)

8. **Pulling or pushing away** is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.

9. **Striking out** is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

**Consolability**

1. **No need to console** is characterized by a sense of well-being. The person appears content.
2. **Distracted or reassured by voice or touch** is characterized by a disruption in the behaviour when the person is spoken to or touched. The behaviour stops during the period of interaction, with no indication that the person is at all distressed.
3. **Unable to console, distract, or reassure** is characterized by the inability to soothe the person or stop a behaviour with words or actions. No amount of comforting, verbal or physical will alleviate the behaviour.
**MOBID–2 Pain Scale**

**Mobilization – Observation – Behaviour – Intensity – Dementia**

<table>
<thead>
<tr>
<th>Patient’s name:</th>
<th>Date:</th>
<th>Time:</th>
<th>Unit:</th>
</tr>
</thead>
</table>

Pay attention to the patient’s pain behaviour during morning care. Observe the patient before you start mobilization. Explain clearly what is going to happen. Guide the patient carefully through the activities 1–5. Reverse the movement immediately if pain behaviour is perceived. Rate your observation after each activity:

### Pain Behaviour

- **Tick the boxes for Pain noises, Facial expression and Defence, whenever you observed such pain behaviour**

### Pain Intensity

- **Based on pain behaviour, rate the pain intensity with a cross on the lines (0–10)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Pain noises</th>
<th>Facial expression</th>
<th>Defence</th>
<th>Pain Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Guide to open both hands, one hand at a time</td>
<td>Ouch! Groaning Screaming</td>
<td>Grimacing Freezing Tightening mouth Closing eyes</td>
<td>Freezing Guarding Pushing Crouching</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>2. Guide to stretch both arms towards head, one arm at a time</td>
<td></td>
<td></td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>3. Guide to stretch and bend both knees and hips, one leg at a time</td>
<td></td>
<td></td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>4. Guide to turn in bed to both sides</td>
<td></td>
<td></td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>5. Guide to sit at the bedside</td>
<td></td>
<td></td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>
Did you observe, today or in the last days (one week), that the patient expressed pain behaviour related to head, internal organs and/or skin, which may be caused by a disease, wound, infection and/or injury?

**Pain Behaviour**

Make one or more cross/es on the pain drawing (front and back), according to observed pain behaviour (Pain noises, Facial expression and Defence)

**Pain Intensity**

Based on pain behaviour, rate the pain intensity with a cross on the lines (0–10)

1. **How intense do you regard the pain to be?**
   - 0 is no pain and 10 is as bad as it possibly could be

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

2. **6. Head, mouth, neck**

3. **7. Heart, lung, chest wall**

4. **8. Abdomen**

5. **9. Pelvis, genital organs**

6. **10. Skin**

7. **Based on all observations, rate the patient’s overall pain intensity**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Baldina, Hzaidah/Julie T., Department of Public Health and Primary Health Care, University of Bergen
APPENDIX 10

STAFF AWARENESS PROGRAMME

BEST PRACTICE APPROACH TO PAIN ASSESSMENT IN DEMENTIA

Introduction

“Dementia is an umbrella term used to denote progressive conditions that develop as a result of degenerative changes in the brain. Dementia primarily affects older people and is characterised by the loss of cognitive, social and behavioural functions that impacts a person’s mood and personality and the ability to think, speak, comprehend, reason, communicate, remember and perform basic self-care functions like dressing and eating. As dementia progresses, the associated behavioural and functional disabilities necessitate the provision of increased daily assistance and care to the individual. Hence, the role of family caregivers in providing care can be significant (The Law Reform Commission, 2006; Cahill et al. 2012; Alzheimer’s Association, 2012)”. Pain is a complex phenomenon and is frequently reported amongst nursing home residents (Hadjistavropoulos et al. 2007, Achterberg et al. 2010). However, pain in people with dementia remains under-detected and misinterpreted (Cohen-Mansfield 2005), thus challenging the care professionals’ nursing care (Nygaard & Jarland 2005, Cunningham et al. 2010). Untreated chronic pain is a devastating symptom in older people with moderate to severe dementia who are unable to explain their suffering (Scherder et al 2009).

CAUSES OF PAIN IN DEMENTIA

- Chronic musculoskeletal pain,
- Arthritis
- Heart disease and peripheral vascular disease
- Falls and fractures
- Pressure ulcers
- Urinary tract infection
- Constipation
- Gastro intestinal complications
- Skin diseases
- Sore gums etc.

SIGNs AND SYMPTOMS OF PAIN IN DEMENTIA

- Behavioural and psychological symptoms such as aggression, agitation and psychosis (hallucinations and delusions).
- Facial expression (e.g.: frowning, grimacing, distorted expression, rapid blinking).
- Verbalisation/vocalisation (e.g. sighing, moaning, calling out, asking for help, verbal abuse etc.
- Body movement (e.g. rigid, tense, guarding, fidgeting, increased pacing/rocking, mobility changes such as inactivity or motor restlessness etc.
- Change in interpersonal interactions (e.g. aggressive, resisting care, disruptive, withdrawn etc.
- change in activity patterns (appetite change, sleep change, sudden cessation of common routine etc
- Change in mental status (e.g. crying, increased confusion irritability distress etc.
- Patient may display increased irritability or aggressive behaviour, increased resistance to personal care requiring active or passive movement, change in appetite or sleep, slowed healing, impaired physical mobility, depressive symptoms or social withdrawal.

REASONS FOR UNDETECTED/ UNDERTREATED PAIN

- The inability of person with dementia to recognise and articulate pain.
- Lack of recognition by cares/nurses of the behavioural and nonverbal signs that someone is in pain.
- Reliance of non-professional staff for the personal care.
• Misconceptions regarding the aging process, believing that it is a part of normal aging process.

• Stigma associated with admission of pain.

• Older people may have a fear of addiction, tolerance, hyper analgesia, and side effects such as constipation or sedation.

• Opioids adversely impact the quality of life is also a common misconception.

• Clinicians underestimate levels of pain

ASSESSMENT OF PAIN IN DEMENTIA

• Self-report of pain

• Search for potential causes of pain or discomfort

• Surrogate Reporting of Pain (e.g., family, caregiver).

• Pain behaviour observational tools.
BEST PRACTICE APPROACH TO PAIN ASSESSMENT.

1. Pain identification is an on-going process that should occur:
   - On admission
   - In the event of a significant changes in resident’s condition
   - Any time pain is suspected
   - At least every three months

2. Pain identification requires a two-part approach, using staff observation techniques and residents’ self-report of pain.
   - ASK the person if he or she is experiencing pain
     - Use YES/NO questions
     - Try words besides pain like hurt/ache/sore
   - LOOK for behavioural signs of pain or discomfort:
     - Observations should be made both when the patient is at rest, and during movement (observe the patient during care activities that require movement such as bathing, dressing, or transfers and/or the physician could conduct gentle range of motion movements with the suspected pain site and watch the patient's reactions)
     - Facial expressions (frowning, grimacing, distorted expression, rapid blinking), verbalizations/vocalizations (sighing, moaning, calling out, asking for help, verbal abuse)
     - Body movements (rigid, tense, guarding, fidgeting, increased pacing/rocking, mobility changes)
   - INVESTIGATE for recent behavioural changes that might be due to pain.
     - Changes in interpersonal interactions (aggressive, resisting care, disruptive, withdrawn)
     - Changes in activity patterns (appetite change, sleep change, sudden cessation of common routines)
     - Mental status changes (crying, increased confusion, irritability, distress).
3. Pain needs to be properly diagnosed so that appropriate and effective management strategies can be planned. Diagnosis will explore the specific type of pain being experienced.

- Nociceptive pain. (Visceral or somatic pain).
- Neuropathic pain
- Pain related to psychological or psychiatric factors.

4. A thorough pain assessment explores multiple factors. These include:

- Pain history
- General medical history
- Physical examination
- Physical impact of the pain
- Social impact of the pain
- Psychosocial factors related to the pain
- A review of medications and treatments
- Severity and intensity of the pain
- Prognosis.

5. The use of an appropriate, structured pain assessment tool will facilitate thorough assessment of a resident’s pain.

*Guideline Created for Geriatrics by L Snow, MP Rapp, M Kunik and Australian pain society.*
APPENDIX 11
KIRKPATRICK’S 4 LEVEL MODEL OF EVALUATION
LEVEL 1 (REACTION PHASE)

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you think that the training was successful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Did you feel that the training was worth with your time?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Did you comfortable with the trainer and the presentation style?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Did you like the materials’ use for presentation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Did you comfortable with the venue?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Did the training session accommodate your personal learning style?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 12

### KIRKPATRICK'S 4 LEVEL MODEL OF EVALUATION

**LEVEL 2 (LEARNING PHASE) - PRE TEST QUESTIONNAIRES**

<table>
<thead>
<tr>
<th>Q.No</th>
<th>Questions</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Poor</th>
<th>Very Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What is dementia? Do you think that pain in people with dementia remains under treated or misinterpreted.</td>
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<td>2</td>
<td>What are the causes of pain in dementia?</td>
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<tr>
<td>3</td>
<td>How you identify pain in dementia or what are the signs and symptoms of pain in dementia?</td>
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<tr>
<td>4</td>
<td>How you will assess pain in people with dementia?</td>
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<tr>
<td>5</td>
<td>Do you know what is the best practice approach to pain assessment in people with dementia?</td>
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<tr>
<td>6</td>
<td>Have you heard of pain assessment tool? Which assessment tool do you use? When and how often do you use?</td>
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<tr>
<td>7</td>
<td>Have you heard of PAINAD and MOBID-2 pain scale? What is your suggestion for updating Abbey pain scale?</td>
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</tbody>
</table>
## APPENDIX 13

**KILKPARICK’S 4 LEVEL MODEL OF EVALUATION**

**LEVEL 2 (LEARNING PHASE) - POST TEST QUESTIONNAIRES**

<table>
<thead>
<tr>
<th>Q. No</th>
<th>Questions</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Poor</th>
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<tr>
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<tr>
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<tr>
<td>8</td>
<td>How do you use MOBID-2 and PAINAD scale?</td>
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